PRINTED: UDIZBIZUTZ DEPARTMENT OF HEALTH AND HUMAN SERVICES ()) FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C OC# B. WING 08/22/2012 445235 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 000 INITIAL COMMENTS F 000 Complaint investigation #30255 and #30291 F309 were completed on August 21 - 22, 2012. No 1. Corrective action for residents deficiencies were cited related to complaint affected: investigation #30255. Deficiencies were cited a.) The Antibiotic order for Resident related to complaint investigatin #30291 under 42 #3 was changed to Avelox on 8/17/12 CFR Part 483, Requirements for Long Term Care and RN#1 was educated by the Nurse Educator on 8/22/12 on properly Facilities. F 309 F 309 | 483.25 PROVIDE CARE/SERVICES FOR filling out telephone orders to reflect SS=E HIGHEST WELL BEING the correct ordering Physician. Resident assessed by the Unit Each resident must receive and the facility must Manager on 8/17/12 with no adverse provide the necessary care and services to attain outcome. or maintain the highest practicable physical, b.) Physician notified of Medication mental, and psychosocial well-being, in Error to Resident #4 on 8/8/12 by the accordance with the comprehensive assessment Unit Manager. Resident assessed by the Unit Manager on 8/8/12 with no and plan of care. adverse outcome. c.) Physician notified of Medication Error to Resident #10 by Unit This REQUIREMENT is not met as evidenced Manager on 8/20/12. Resident assessed by the Unit Manager on Based on medical record review, observation, 8/20/12 with no adverse outcome. and interview, the facility failed to follow d.) Physician notified of Medication physician's orders for three (#3, #4, #10, and #13) Error by the Unit Managerto Resident of eighteen residents reviewed. #13 on 8/20/12. Resident assessed by the Unit Manager on 8/20/12 with no The findings included: adverse outcome. Resident #3 was admitted to the facility on August 2. Identification of others who could be 6, 2012, with diagnoses including Left Foot affected by the deficient practice: Transmetatarsal Amputation, Cellulitis Left Foot, The Director of Nursing and/or Unit Osteomyelitis, Diabetes, Chronic Pain Syndrome, Managers audited all Congestive Heart Failure, Peripheral Vascular physician orders on current residents Disease, and Peripheral Neuropathy. for compliance 8/23/12 - 9/5/12. No other residents found to be Medical record review of a physician's order, affected. signed by the resident's physician, dated August (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE ministrator 9-12-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the above findings and plans of correction are disclosable 14 following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	,		LDING		١,	c l
		445235	B. WING			08/22/2012	
	ROVIDER OR SUPPLIER ARD TERRACE REH	ABILITATION AND NURSING HOM	1E	18	EET ADDRESS, CITY, STATE, ZIP CODE 530 MIDDLE TENNESSEE BLVD IURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	NULD BE	(X6) COMPLETION DATE
F 309	8, 2012, revealed (antibiotic) 500 mg (every) day til 9/1/1 po q day (as per he Metronidazole (for anaerobic microorge/1/12" Medical record revedated August 9, 20 mg, Levafloxacin for skin infection, I day til 9/1/12 for skin infectious review of the August 9, 20 Registered Nurse from the infectious review of the phys 2012, revealed in notation stating "Digive this order" Medical record revented the Medication Administration Administration Review of the August 10-17, 2012, and times a day on Aureview of the August 10-17, 2012. Observation on Airevealed the resident received the Airevealed the resident revealed the resident received the Airevealed the resident revealed the resident reve	D/C (discontinue) Levofloxacin (milligrams) 1 po (by mouth) q 12, Avelox (antibiotic) 400 mg 1 psp (hospital) orders) D/C bacterial infections caused by ganisms) 500 mg tid until view of a physician's order 12, revealed "D/C Avelox 400 mg PO daily til (until) 9/1/12 Metronidazole 500 mg 3 times a kin infection. Continued review 12, physician's order revealed (RN #1) had received this order disease physician. Continued ician's order dated August 9, a different had writing a br. (infectious disease) did not view of the August 2012, istration Record revealed the Levofloxacin 500 mg on August Metronidazole 500 mg three igust 10-17, 2012. Continued ust 2012, Medication cord revealed the resident did avelox as ordered on August 10 ugust 21, 2012, at 10:20 a.m., lent lying on the bed with a	F	309	3. Measures put in place to ensure deficient practice does not reocculicensed Nurses on Medication Administration, Telephone Or Input of orders into the electron medical system and reviewing on new admits for accuracy 8/9/7/12. New Nurses will be inserviced by the Nurse Educaturing the orientation process. 4. Systems to monitor the effection. The Director of Nursing, Unit Marand Medical Records will audicated admit orders, telephone orders the Electronic Medical System accuracy, for a total of 20 resing weekly for 4 weeks, then twice monthly for 2 months and/or a 100% compliant. b.) Findings will be reported to by the Director of Nursing to Quality Assurance Performant Improvement Committee corrof: Administrator, Director of Nursing, Medical Director, Undirector, Medical Records Nursing, Medical Records Nursing Managers, Restorative Managers Nurse Educator, Social Service Director, Medical Records Nursing Manager, Activity Coordinator, MDS Coordinated Housekeeping Director, There Manager, Maintenance Direct Admissions Coordinator.	ders, onic orders 23/12 - ator orders assistant nagers, it new s, and ordents are contil monthly the ce opprised f nit ger, ces arse, or,	9/12/1 10/2/1:

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: B6N611

Facility ID: TN7502

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PRINTED. VOIZBIAN FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B, WING 08/22/2012 445235 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 2 improving, decreasing in size and there was less drainage from the foot. Continued interview revealed Levofloxacin was in the same class of antibiotics as the Avelox, and confirmed the Levofloxacin with the Metronidazole were effective medications to treat the resident's wound, however the Avelox was the medication preferred by the physician. Interview on August 22, 2012, at 8:20 a.m., with RN #1 in the conference room, revealed RN #1 had received the order to discontinue the Avelox. and start Levofloxacin and Metronidazole from the infectious disease physician's nurse on August 7, 2012. Continued interview confirmed RN #1 did not receive an order on August 9, 2012, from the infectious disease physician to discontinue the Avelox and to administer the Levofloxacin and Metronidazole. Continued interview confirmed the resident received the Levofloxacin and the Metronidazole from August 10 - 17, 2012, without a physician's order. Continued interview confirmed the resident did not received the Avelox August 10 -17, 2012, as ordered by the physician. Resident #4 was admitted to the facility on July 17, 2012, with diagnoses including Peripheral Vascular Disease, Chronic Obstructive Pulmonary Disease, Arthritis, and Congestive Heart Failure. Medical record review revealed the resident was discharged home on August 16,

prn (as needed)."

Medical record review of a physician's order dated August 7, 2012, revealed "...Miralax 17 g (grams) po tonight x (times) 1 then qd (every day)

2012.

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445235	B. WING			C 08/22/2012	
	NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HO			15	EET ADDRESS, CITY, STATE, ZIP COD 530 MIDDLE TENNESSEE BLVD IURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ige 3	F	309		-	
	Medication Adminis	ew of the August 2012, stration Record revealed no Miralax was administered on					
	August 8, 2012, rev	ew of a physician's note dated realed "Constipation - did not lered last PM (evening)"					
	the Assistant Direction conference room, of	et 22, 2012, at 9:15 a.m., with tor of Nursing in the confirmed the resident did not as ordered on August 7,					
	August 17, 2012, v	admitted to the facility on vith diagnoses including Stage Renal Disease.					
	physician's orders physician on Augus	iew of the admission dated as signed by the hospital st 18, 2012, (per Director of ian must have signed the					
	Novolog sliding sca bedtime as follows Glucose 201 - 250	ed the resident was to receive ale insulin before meals and at : Glucose 150 - 200, 4 units; , 8 units; Glucose 251 - 300, 12 - 350, 16 units; Glucose 351 - call the physician.					
	Medication Admini resident's glucose administered before the following pararunits; Glucose 251	iew of the August 2012, stration Record revealed the was checked and insulin re meals and at bedtime using meters: Glucose 201 - 250, 2 - 300, 4 units; Glucose 301 - ose 351 - 400, 8 units; and					

FRINGLED. DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 08/22/2012 445235 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES Œ (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 309 Continued From page 4 F 309 greater than 400, 10 units and notify the physician. Medical record review revealed no physician's order to change the parameters for insulin administration. Interview on August 22, 2012, at 12:05 p.m., with the Director of Nursing, in the conference room, revealed the resident's sliding scale insulin was changed to the facility's Standing Orders for sliding scale insulin upon admission to the facility. and confirmed there was no physician's order to change the sliding scale insulin to the facility's standing orders.

FORM CMS-2567(02-99) Previous Versions Obsolete

sleep)..."

insulin administration.

Heart Failure.

Interview on August 22, 2012, at 12:15 p.m., with the physician/Medical Director, in the conference room, revealed the physician had not approved the facility's standing orders for sliding scale

Resident #13 was admitted to the facility on August 18, 2012, with diagnoses including Glaucoma, Atrial Fibrillation, and Congestive

Medical record review of the admission physician orders dated August 16, 2012, from the hospital, revealed the resident was to receive Lumigan (antiglaucoma) 0.03% ophthalmic solution.

Medical record review of a physician's order dated August 20, 2012, revealed "Lumigan 1 gtt (drop) to ea. (each) eye q (every) hs (hour of

Medical record review of the August 2012,

Event ID: B6N611

Facility ID: TN7502

If continuation sheet Page 5 of 17

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION N		IDENTIFICATION NUMBER:	A. BUILD	NG	COMPLETED	
		445235	B. WING		08/22/2012	
	ROVIDER OR SUPPLIER ARD TERRACE REHA	ABILITATION AND NURSING HOM	1	TREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		ULD BE COMPLETION DATE	
F 309	documentation the on August 18 or 19 Interview on Augus revealed the physic not transcribed from confirmed the resid Lumigan on August by the physician.	stration Record revealed no resident received the Lumigan , 2012. It 22, 2012, at 11:00 a.m., sian's order for Lumigan was in the admission orders and lent did not receive the t 18 and 19, 2012, as ordered	F 30	F333		
SS=D	The facility must er any significant med	D ERRORS Insure that residents are free of lication errors.	F 33	affected: Physician notified of Medicati Error to Resident #10 by the U Manager on 8/20/12. Resident assessed by the Unit Manager adverse outcome.	on Jnit t	
	by: Based on medical and interview, the f	İ		2. Identification of others who co affected by the deficient practice: All Sliding Scale Insulin order audited by the Director of Nurs and Unit Managers on 8/23/12 accuracy and found to be comp. No other residents found to be affected.	s were sing for	
	August 17, 2012, w Diabetes, and End Medical record revi physician's orders physician on Augus Nursing the physici wrong date) reveal	admitted to the facility on vith diagnoses including Stage Renal Disease. siew of the admission dated as signed by the hospital st 18, 2012, (per Director of ian must have signed the ed the resident was to receive ale insulin before meals and at		3. Measures put in place to ensure deficient practice does not reoccu. The Nurse Educator inserviced licensed Nurses on Sliding Sca Insulin orders and Medication Administration 8/23/12 - 9/7/1 New Nurses will be inserviced Nurse Educator during the ories process.	r: le 2. by the	

(X2) MULTIPLE CONSTRUCTION

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING С B. WING 08/22/2012 445235 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 333 4. Systems to monitor the effectiveness: F 333 Continued From page 6 a) The Director of Nursing, bedfime as follows: Glucose 150 - 200, 4 units; Assistant Director of Nursing, Glucose 201 - 250, 8 units; Glucose 251 - 300, 12 Unit Managers, and Medical units: Glucose 301 - 350, 16 units; Glucose 351 -Records will audit new 400, 20 units and call the physician. admission orders and telephone orders with sliding scale insulin Medical record review of the August 2012. for accuracy, for a total of 20 Medication Administration Record revealed the residents weekly for 4 weeks. resident's glucose was checked and insulin then twice monthly for 2 months administered before meals and at bedtime using and/or until 100% compliant. the following parameters: Glucose 201 - 250, 2 b) Findings will be reported units; Glucose 251-300, 4 units; Glucose 301 monthly by the Director of 350, 6 units; Glucose 351 - 400, 8 units; and Nursing to the Quality Assurance greater than 400, 10 units and notify the Performance Improvement physician. Committee comprised of: Administrator, Director of Medical record review revealed no physician's Nursing, Medical Director, Unit order to change the parameters for insulin Managers, Restorative Manager, administration. Nurse Educator, Social Services Director, Medical Records Medical record review of the August 2012, Nurse, Dietary Manager, Activity Medication Administration Record revealed the Coordinator, MDS Coordinator, resident received Novolog sliding scale insulin as Peradmunded Housekeeping Director, Therapy follows: on August 17, 2012, at 9:00 p.m., the Manager, Maintenance Director, resident's blood sugar was 162 and no insulin and Admissions Coordinator. was administered; on August 18, 2012 at 7:30 a.m., the resident's blood sugar was 280 and 4 units of insulin was administered; on August 18, 2012, at 11:30 a.m., the resident's blood sugar was 287 and 4 units of insulin was administered; on August 18, 2012, at 4:30 p.m., the resident's blood sugar was 361 and 8 units of insulin was administered; on August 18, 2012, at 9:00 p.m., the resident's blood sugar was 259 and 4 units of insulin was administered; on August 19, 2012, at 7:30 a.m., the resident's blood sugar was 200 and no insulin was administered; on August 19,

2012, at 11:30 a.m., the resident's blood sugar was 248 and 2 units of insulin was administered;

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	445235 B. WING		·	08/22) 2/2012		
	NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HO			15	EET ADDRESS, CITY, STATE, ZIP CODE 30 MIDDLE TENNESSEE BLVD URFREESBORO, TN 37130	00.22	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	,	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULDBE	(X5) COMPLETION DATE
F 333	on August 19, 2013 blood sugar was 2-administered; on A the resident's blood insulin was admini 2012, at 7:30 a.m. was 196 and no in Medical record revidated August 20, 2 scale) Novolog (insulin); 15, 0 (insulin); 15 (subcutaneous); 2 301 - 350, 8u sq; 3 Observation on August the Director of Nurevealed the resident had just completed interview on August he Director of Nurevealed the resident changed to the facts of the sliding scale insuling and confirmed the change the sliding standing orders. Interview on August he physician/Medical revealed the resident change the sliding standing orders.	2, at 4:30 p.m., the resident's 46 and 2 units of insulin was august 19, 2012, at 9:00 p.m., d sugar was 278 and 4 units of stered; and on August 20, the resident's blood sugar sulin was administered. siew of a physician's order 2012, revealed "SS (sliding sulin): 0 - 60, 0 (insulin); 61 - 61 - 250, 4u sq; 251 - 300, 6u; 351 - 400, 10u; 401+, 12u sq." august 22, 2012, at 8:50 a.m., ent lying on the bed, awake and d the breakfast meal. st 22, 2012, at 12:05 p.m., with rsing, in the conference room, ent's sliding scale insulin was cililty's Standing Orders for in upon admission to the facility are was no physician's order to g scale insulin to the facility's ast 22, 2012, at 12:15 p.m., with fical Director, in the conference e physician had not approved ing orders for sliding scale	F	333			
F 386 SS=D		CIAN VISITS - REVIEW RDERS	F	386			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILI	LTIPLE CONSTRUCTION DING	COMPLE	(X3) DATE SURVEY COMPLETED		
		445235	B. WING	·		C 08/22/2012	
	ROVIDER OR SUPPLIER	ABILITATION AND NURSING HOM		STREET ADDRESS, CITY, STATE, Z 1530 MIDDLE TENNESSEE BL MURFREESBORO, TN 371	IP CODE VD		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION			(X5) COMPLETION DATE	
F 386	The physician mus program of care, in treatments, at each of this section; writh notes at each visit; with the exception polysaccharide vac administered per policy after an asset. This REQUIREME by: Based on medical documentation revialled to follow the the Medical Director physician's signature. The findings include Resident #18 was 16, 2012, with diagonal Chronic renal failured Vascular Accident. Medical record revorders dated May 7 Director's signature order dated May 7 Director's signature indicate the physician approved the order dated Review of facility of 14, 2005, regarding rubber signature sindividual in control	t review the resident's total acluding medications and a visit required by paragraph (c) e, sign, and date progress and sign and date all orders of influenza and pneumococcal scines, which may be hysician-approved facility essment for contraindications. NT is not met as evidenced record review, facility iew, and interview, the facility written agreement in place with or regarding the use of the prestamp. Ied: admitted to the facility on May gnoses including Acute and re, History of a Cerebral and Diabetes Mellitus. iew revealed three telephone 1, 2012, and one telephone 2012, with the former Medical e stamp and no date or time to the sian had reviewed and	F 36	1. Corrective action for affected: Previous Medical Distamp from facility of stamp from facility of 2. Identification of other affected by the deficient Stamps are no longer facility. All resident by Director of Nursin and no longer affect practice. 3. Measures put in place deficient practice does not make the current practice with the current director regarding signall orders in black in All licensed nurses a inserviced by the Nurubber stamp no long this facility 8/23/12 nurses will be inserved action to the current process of the nurses will be inserved action of the current process of t	rector removed on 7/15/12. rs who could be a practice: r a practice in orders assessed ing on 8/23/12 ed by this e to ensure not reoccur: completed an interest medical gining and dating is on 8/29/12. re aware and insee Educator that iger a practice in 9/12/12. New iced by the Nurse intation. The effectiveness: In and/or ector will audit for physician is in weekly for ince monthly for incertain in the second in the		

Facility ID: TN7502

PRINTED: 08/29/2012 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING C B. WING 08/22/2012 445235 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ΙĐ (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 386 F 386 Continued From page 9 b.) Findings will be reported monthly by the Director of Nursing to the documentation, I am attesting that I personally stamped this document on the date indicated..." Quality Assurance Performance Improvement Committee comprised (document signed by the former medical of: Administrator, Director of director). Nursing, Medical Director, Unit Managers, Restorative Manager, Interview on August 22, 2012, at 11:30 a.m. with Licensed practical Nurse (LPN) #2 revealed the Nurse Educator, Social Services Director, Medical Records Nurse, LPN routinely used the physician's signature stamp on medical record documents and Dietary Manager, Activity physician's orders. The LPN stated the stamp is Coordinator, MDS Coordinator, Housekeeping Director, Therapy used in the medical records office, by the LPN Manager, Maintenance Director, and following the medical director's review of orders, 10/2/12 lab results, and other medical record documents. Admissions Coordinator. The LPN confirmed the orders were not dated to indicate the medical director had reviewed and approved the physician's orders and the physician was not the only person with access to the signature stamp. Telephone interview on August 22, 2012, at 12:20 p.m., with the former medical director, confirmed the physician was aware the medical records F425 LPN had access to and used the signature stamp on medical record documents. 1. Corrective action for residents affected: C/O #30291 Physician notified of Medication 483.60(a),(b) PHARMACEUTICAL SVC -F 425 F 425 Error to resident #3 by the Unit ACCURATE PROCEDURES, RPH SS=D Manager on 8/7/12. Resident assessed by Unit Manager on 8/7/12

The facility must provide routine and emergency

drugs and biologicals to its residents, or obtain

§483.75(h) of this part. The facility may permit

A facility must provide pharmaceutical services

unlicensed personnel to administer drugs if State

them under an agreement described in

law permits, but only under the general

supervision of a licensed nurse.

with no adverse outcome.

affected by the deficient practice:

by the Unit Mangers on 8/23/12 for

found to be affected..

availability of medication and all were found to be compliant. No other resident

2. Identification of others who could be

Audit of current residents was done

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		445235	B. WIN		· · · · · · · · · · · · · · · · · · ·		C 2/2012
	ROVIDER OR SUPPLIER ARD TERRACE REH	IABILITATION AND NURSING HOM	ΛE	15	EET ADDRESS, CITY, STATE, ZIP CODE 30 MIDDLE TENNESSEE BLVD URFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CO PREFIX (EACH CORRECTIVE ACTION TAG CROSS-REFERENCED TO THE DEFICIENCY)		ULD BE	(X5) COMPLETION DATE
F 425	(including procedu acquiring, receivin administering of al the needs of each The facility must e a licensed pharma	res that assure the accurate g, dispensing, and ll drugs and biologicals) to meet resident. Employ or obtain the services of acist who provides consultation the provision of pharmacy	F	425	3. Measures put in place to ensur deficient practice does not reoccua.) In-service provided to licer nursing staff by Nurse Educate 8/23/12 - 9/7/12 regarding telenotification of pharmacy of neorders. New staff to be inservithe Nurse Educator during the orientation process. b.) In-service provided to lice nursing staff by Nurse Educate 8/23/12 - 9/7/12 regarding M notification of unavailable medications and obtaining or therapeutic alternative available	or: ased or ephone ow iced by ased or D der for ole in	
	by: Based on medica the facility failed to	ENT is not met as evidenced at record review and interview, poprovide timely pharmacy #3) of eighteen residents			emergency facility meds. Ne to be inserviced by the Nurse Educator during the orientatio process. 4. Systems to monitor the effecti a.) Director of Nursing and/or Manager to audit MAR of 3 r	on veness: r Unit	
	6, 2012, with diag Transmetatarsal Diabetes, Chronic Heart Failure, Per Peripheral Neuro Medical record redated August 6, 2 to receive Avelox by mouth every dedical Administresident did not resident did not res	admitted to the facility on August noses including Left Foot Amputation, Cellulitis Left Foot, Pain Syndrome, Congestive ripheral Vascular Disease, and pathy. Inview of the admission orders (2012, revealed the resident was (antibiotic) 400 mg (milligrams), ay, through September 1, 2012. Inview of the August 2012, ration Record revealed the eceive the Avelox 400 mg and			weekly for 4 weeks, then twick monthly for 2 months and/or 100% compliant for availability ordered medications. b.) Findings will be reported a by the Director of Nursing to Quality Assurance Performan Improvement Committee com of: Administrator, Director of Nursing, Medical Director, Un Managers, Restorative Manag Nurse Educator, Social Service Director, Medical Records Nu Dietary Manager, Activity Coordinator, MDS Coordinator Housekeeping Director, Thera	ee until ity of monthly the ce prised f nit er, es urse,	9/12/18
	was on order on				Manager, Maintenance Direct Admissions Coordinator.	or, and	-10/2 7

(X2) MULTIPLE CONSTRUCTION

If continuation sheet Page 11 of 17
Peradministrator

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		445235 B. WING			C 08/22/2012		
	NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HO				ET ADDRESS, CITY, STATE, ZIP CODE 10 MIDDLE TENNESSEE BLVD JRFREESBORO, TN 37130		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 425	Continued From pa	age 11 w on August 23, 2012, at 9:10	F	125			
	a.m., with the Dire	ctor of Nursing confirmed the allable for administration on		9	F502		
F 502 SS=D	services to meet the facility is responsite of the services. This REQUIREMED by: Based on medicate the facility failed to ordered for two (# residents reviewed) The findings inclusive facility failed to ordered for two (# residents reviewed) The findings inclusive facility with diagonal poisorder, Chronic Disease, and Hypometrical facility with diagonal facility faci	rovide or obtain laboratory ne needs of its residents. The ble for the quality and timeliness ENT is not met as evidenced if record review and interview, b obtain laboratory levels as 12, #16) residents of eighteen d. ded: c admitted to the facility on July noses including Depressive Obstructive Pulmonary		502	 Corrective action for residen affected: a.) Physician notified by the Manager and lab drawn on 8 ordered on Resident #12 wit value found to be within nor range. b.) Physician notified by the Manager and orders received lab on 8/20/12 and found to normal range. c.) Hospital Lab Results obtothe Unit Manager for Reside on 8/22/12 and found to be normal range. Identification of others who affected by the deficient praction a.) Director of Nursing, Associated by the deficient practice and the starting 8/23/12 - 9/7/12. The residents found to be affected. Measures put in place to endeficient practice does not residents. 	Unit /20/12 as h lab mal Unit d to draw be within ained by ent # 16 within could be ice: sistant nit ab orders No other ted.	
	therapy" Medical record re July 26, 2012, re- (reference range	rd review of a laboratory report dated 2, revealed "Potassium 2.8 Inge) 3.4-5.1Critical ValueCalled ober)" Further review revealed no			a.) Licensed nurses inserviced by Nurse Educator 8/23/12 - 9/7/12 on utilization of lab calendars. New nurses will be inserviced by the Nu Educator during the orientation process.		

PRINTED: USIZSIZUTZ FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING C B. WING 08/22/2012 445235 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1530 MIDDLE TENNESSEE BLVD BOULEVARD TERRACE REHABILITATION AND NURSING HOME MURFREESBORO, TN 37130 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 502 4. Systems to monitor the effectiveness: F 502 | Continued From page 12 Magnesium level had been obtained on July 26, a.) Lab orders are to be compared to calendar by Director of Nursing 2012. and/or Unit Managers on 10 lab Medical record review of a physician's order orders weekly for 4 weeks and then dated July 26, 2012, revealed "...Potassium 40 twice monthly for 2 months and/or MeQ (milliequilvents) now...Potassium 20 MeQ until 100% compliant. daily...(Potassium) level 7/31/12..." b.) Findings will be reported monthly by the Director of Nursing to the Medical record review revealed no Potassium Quality Assurance Performance level had been obtained on July 31, 2012. Improvement Committee comprised of: Administrator, Director of Medical record review of a physician's order Nursing, Medical Director, Unit dated August 20, 2012, revealed "...Stat (now) K Managers, Restorative Manager, (potassium) level...pt (patient) (with) (low) K..." Nurse Educator, Social Services Director, Medical Records Nurse, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator. Pull 12 10/2/12 Medical record review of a laboratory report dated August 20, 2012, revealed "...Potassium 4.5... (reference range) 3.4-5.1..." Interview on August 22, 2012, at 11:30 a.m., with the Director of Nursing, in the conference room, confirmed the Magnesium level had not been obtained on July 26, 2012, and the Potassium level had not been obtained on July 31, 2012.

2012.

Resident #16 was admitted to the facility on February 25, 2003, with diagnoses including Diabetes, Esophageal Reflux, and Anxiety.

Medical record review of a physician's order dated August 13, 2012, revealed "...BMP (Basic Metabolic Profile) Mg (Magnesium) Fri (Friday) (August 17, 2012) am re (regarding) (low) K..."

Medical record review revealed no laboratory results for a BMP and Mg level on August 17,

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 08/29/2012 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	}`		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
· - · · ·	<u>-</u>	.,,,,,,	B. WING			С		
		445235			· · · · · · · · · · · · · · · · · · ·	08/2	2/2012	
	NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HO				ET ADDRESS, CITY, STATE, ZIP CODE 30 MIDDLE TENNESSEE BLVD URFREESBORO, TN 37130			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 502	the Director of Nur	st 22, 2012, at 12:15 p.m., with sing (DON), in the conference	F 5	502				
F 505 SS=D	obtained as ordered C/O #30291 483.75(j)(2)(ii) PROOF LAB RESULTS The facility must pi physician of the fine This REQUIREME by: Based on medical the facility failed to	romptly notify the attending dings. NT is not met as evidenced record review and interview, notify the physician timely of for one (#11) resident of	F	605	F505 1. Corrective action for resident affected: Physician notified by Licens and order obtained for medic Resident #11 on 8/20/12. Reassessed by Unit Manager or with no adverse outcome. 2. Identification of others who	ed Nurse eation for esident 1 8/20/12		
	The findings include Resident #11 was November 12, 199				affected by the deficient practic Director of Nursing and Unit Managers conducted an audi 8/23/12 - 9/7/12 for notificat physician. No other resident be affected.	of labs		
	August 18, 2012, UrineFinal Repo (greater than) 100 Medical record red dated August 20, (antibiotic) 500 mg (every) day x 7 d	view of a laboratory report dated revealed "Bacterial Culture and Verified: 08/18/2012, 000Enterococcus species" view of a physician's order 2012, revealed "Levaquin g (milligrams) 1 po (by mouth) q .UTI (urinary tract infection)"			3. Measures put in place to ensu deficient practice does not reocce Licensed nurses educated by Nurse Educator on timely not of physician/physician on cal - 9/7/12. New nurses to be in by Nurse Educator during the orientation process.	the ification 18/23/12 serviced		

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: TN7502

4. Systems to monitor the effectiveness:

a.) Director of Nursing and/or Unit Managers to review labs ordered on 10 residents weekly for 4 weeks, then twice monthly for 2 months and/or until 100% compliant for notification of Physician and any orders received. b.) Findings will be reported monthly by the Director of Nursing to the Quality Assurance Performance Improvement Committee comprised of: Administrator, Director of Nursing, Medical Director, Unit Managers, Restorative Manager, Nurse Educator, Social Services Director, Medical Records Nurse, Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, and Admissions Coordinator.

۹,

9/12/12 Per administrator

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		445235	A. BUILDING B. WING			C 08/22/2012	
	ROVIDER OR SUPPLIER	ABILITATION AND NURSING HO	VIE	15	ET ADDRESS, CITY, STATE, ZIP CODI 30 MIDDLE TENNESSEE BLVD JRFREESBORO, TN 37130		
(X4) ID PREFIX TAG	/FACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 505	confirmed was not results until Augus C/O #30291 483.75(I)(1) RES RECORDS-COMFLE The facility must resident in accord standards and preaccurately docum systematically org The clinical record information to ide resident's assess services provided preadmission screamd progress note This REQUIREM by: Based on medicate facility failed to record for one reaccomplete medicate of eighteen resident #3 was 6, 2012, with diate Transmetatarsal Osteomyelitis. D	or in the conference room, notified of the urine culture of 20, 2012 (two day delay). PLETE/ACCURATE/ACCESSIB maintain clinical records on each ance with accepted professional actices that are complete; ented; readily accessible; and ranized. If must contain sufficient ntify the resident; a record of the ments; the plan of care and it; the results of any eening conducted by the State; es. ENT is not met as evidenced all record review and interview, to maintain an accurate medical sident (#3) and failed to maintain cal record for one resident (#18) ents reviewed.	F st	505	F514 1. Corrective action for reside affected: a.) The Antibiotic order for #3 was changed to Avelox and RN#1 was educated by Educator on 8/22/12 on profilling out telephone order the correct ordering Physic Resident assessed by the Umanager on 8/17/12 with soutcome. b.) Discharge summary con Resident #18 by Licensed Nurse on 8/23/12. 2. Identification of others what affected by the deficient prace a.) An audit for completion discharge summaries on redischarged from the facility 90 days was done by the Records Director on 8/23/15. The Director of Nursin Unit Managers audited all physician orders on current for compliance 8/23/12 No other residents found affected	r Resident on 8/17/12 y the Nurse operly s to reflect cian. Unit no adverse mpleted on Practical o could be tice: on of esidents y in the last fedical 12. g and/or int residents 9/5/12.	

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STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA		ULTIP	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	CORRECTION	DENTIFICATION NUMBER:	A. BUI	LDING	<u> </u>		1
		445235	B. WING			C 08/22/2012	
i	NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND NURSING HE				EET ADDRESS, CITY, STATE, ZIP CODE 530 MIDDLE TENNESSEE BLVD WRFREESBORO, TN 37130		!
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 514	Disease, and Perip Medical record rev dated August 9, 20 (discontinue) Avelo (milligrams), Levaf (by mouth) daily til Metronidazole (for anaerobic microor til 9/1/12 for skin ir the August 9, 2012 Registered Nurse from the infectious review of the phys 2012, revealed in notation stating "D give this order" Interview on Augu RN #1 in the confe did not receive an the infectious dise the Avelox and to Metronidazole. Resident #18 was 16, 2012, with dia Chronic renal failt Vascular Acciden Medical record re discharged to the expired in the hos facility failed to in detailing the resid	iew of a physician's order of 2, revealed "D/C ox (antibiotic) 400 mg loxacin (antibiotic) 500 mg PO 9/1/12 for skin infection, bacterial infections caused by ganisms) 500 mg 3 times a day of ection. Continued review of 2, physician's order indicated (RN) #1 had received this order of disease physician. Continued ician's order dated August 9, a different hand writing a pr. (infectious disease) did not est 22, 2012, at 8:20 a.m., with evence room, confirmed RN #1 order on August 9, 2012, from ease physician to discontinue administer the Levofloxacin and administer the Levofloxacin and the tand Diabetes Mellitus. View revealed the resident was hospital on June 1, 2012, and spital on June 5, 2012. The clude a discharge summary tent's medical treatment and		514	3. Measures put in place to ensur deficient practice does not reoccu. a.) The Nurse Educator inservilicensed nurses on telephone a clarification orders 8/23/12 - New nurses to be inserviced by Nurse Educator during the orioprocess. b.) The Nurse Educator inserving Medical Records on completic closing of discharge charts on c.) The Nurse Educator inservilicensed nursing on completion discharge summaries on day of discharge from the facility 8/2 9/7/12. New nurses to be inservited by the Nurse Educator during orientation process. 4. Systems to monitor the effection. The Director of Nursing and Unit Managers will audit teleorders and the Electronic Messystem for accuracy, for a torresidents weekly for 4 weeks twice monthly for 2 months a until 100% compliant. b.) Director of Nursing and/offended Records Director will discharged resident's charts in presence of discharge summare.) Findings will be reported by the Director of Nursing to Quality Assurance Performant Improvement Committee confice Administrator, Director, Unitsing, Medical Director, Unitsing, Medical Director, Unitsing, Restorative Managers, Res	ir: iced all ind 9/7/12. y the entation iced on and 9/7/12. iced iced on of of 23/12 - erviced the entation iced on of of iced on	
	condition during t	he course of the resident's stay 16, 2012 through June 1, 2012.			Managers, Restorative Mana Nurse Educator, Social Serv	iger, ices	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM / OMB NO.	APPROVED 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
445235			B. WING		C 08/22/2012	
	ROVIDER OR SUPPLIER ARD TERRACE REH	ABILITATION AND NURSING HOM	AE 19	EET ADDRESS, CITY, STATE, ZIP CODE 530 MIDDLE TENNESSEE BLVD IURFREESBORO, TN 37130		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
F 514	Licensed Practical at 10:30 a.m., in the confirmed no disch completed for resident's discharge 2012. Continued in	Director of Nursing and Nurse #2 on August 22, 2012, he medical records office, harge summary had been dent #18, following the ge to the hospital on June 1, interview confirmed without the ry the resident medical record	F 514	Dietary Manager, Activity Coordinator, MDS Coordinator, Housekeeping Director, Therapy Manager, Maintenance Director, at Admissions Coordinator.	adgrupi	9/12/12 2 strator

FORM APPROVED